WAL★MART®
PHARMACY

WAL-MART PHARMACY AUTHORIZATION

Customer Release Of Protected Health Information

CUSTOMER INFORMATION

Customer (Person for whom request is made) _____

Customer's Date of Birth _____ Telephone Number _____

Customer's Address _____

AUTHORIZATION

I authorize the Pharmacy at location_____ and its business associates to release the Protected Health Information to the people, groups, or organizations that are listed below: ***(Attach additional pages if necessary.)***

Name _____

Address _____

I authorize the Pharmacy to release my Protected Health Information from:

- ❑ Prescription _____
- ❑ Medical Expense Summary (listing of all prescription expenses)
- ❑ Designated Record Set (listing of all health information maintained by the pharmacy)
  Date Range Requested From_____ To_____

REASON FOR REQUEST

You may check the box below that states "At customer's request" or you may specify below the reasons you are authorizing the Pharmacy to share your Protected Health Information.

❑ At the customer's request

❑ Other reasons (specify) _____

SIGNATURE

I understand that:

- This Authorization is valid for one (1) year from the date of my signature.
- I have the right to cancel this Authorization at anytime by completing a hard copy Cancellation of Authorization.
- If the Pharmacy has already released my health information that information will be exempt from my cancellation.
- If the person or entity that receives my health information is not required to comply with the federal privacy regulations, the information would no longer be protected by those regulations.

I understand that receipt of Pharmacy services is not contingent upon my signing this form. I understand that if I do not sign this form, the authorization will be invalid.

_____ _____

Customer's Signature Date

If you have signed this form as a legally-recognized representative of the customer, please print your name below and your relationship to the customer that allows you to act on their behalf by signing this form.

Name of Representative (please print) _____ Relationship _____

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Pharmacy will obtain a valid, signed authorization from a customer prior to using or releasing the member's Protected Health Information, unless the customer's authorization is not legally required by law.

If you do not receive a response regarding this form within 45 days, you may assume that this request has been granted.

FOR PHARMACY USE ONLY:

Date Granted _____ Date Denied _____

HIPAA
BFOP-05A